PLEASE DO NOT SEND FORM WITH SAMPLE;
Send this form to Impact Genetics
BY FAX TO 905. 697. 9786
For patient pay, testing will be held pending receipt of this completed form.

Dynacare®

Form 1d: Credit Card Authorization for Non-Covered Services

To be completed by and returned to Impact Genetics directly by the cardholder.

Billing Information

Laboratory Test:

- ☐ Retinoblastoma Genetic Test
- ☐ HHT Genetic Test
- ☐ Epilepsy Gene Panel Test
- ☐ *MLH1/MSH2/MSH6/PMS2/EPCAM* Somatic Tumor MMR Sequencing and Deletion/Duplication Test
- ☐ Uveal Melanoma Prognostic Genetic Test
- ☐ Uveal Melanoma 5 Gene Panel *(SF3B1/ EIF1AX/GNAQ/GNA11/BAP1)*
- ☐ *BAP1*-TPDS (*BAP1* Tumor Predisposition Syndrome) Genetic Test

Patient name:_____ Date of birth: Y_____ M_____ D_____

☐ **VISA** ☐ **MASTERCARD**

Name on card:_____

Billing address:_____

City:_____

Province/State:_____ Postal/Zip code:_____

Country:_____

Card #:_____ Expiration date:_____

Contact Information

Impact Genetics will contact the cardholder prior to placing the credit card charge, to confirm the date and amount of the charge. **Please provide at least 2 contact methods** and check preferred:

☐ Phone:_____

☐ Email:_____

☐ Fax:_____

Statement of Financial Responsibility

Box below must be checked for testing to proceed.

☐ **I understand that my insurance plan is not expected to pay for these test(s) at 100% and I agree to be personally and fully responsible for payment**.

Cardholder's signature:_____ Date:_____